Wisconsin Medicaid
Nursing Home Certification Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746. Information is included in your certification materials regarding electronic submission of claims.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Peggy B. Handrich

Peggy B. Handrich
Administrator

PBH:mhy
MA11065.KZ/PERM

Enclosure

Wisconsin Medicaid
Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The required items must be completed and returned to Wisconsin Medicaid:

	Item	Required	Optional	Date Sent
1.	Provider Application	X		
2.	Provider Agreement (2 copies)	X		

These items are included for your information. Do not return them:

	Item
1.	General Information
2.	Electronic Billing Information

Wisconsin Medicaid Program
General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

Notification of Certification Decision

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

Notification of Changes

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance**. This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

Provider Agreement Form

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

Terms of Reimbursement (TOR)

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

Certification Requirements

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

Publications

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

WISCONSIN MEDICAID

NURSING HOME PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

IMPORTANT NOTICE: In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.

2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.

3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.

4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

DISTRIBUTION — Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006

If you have any questions, call Provider Services at (800) 947-9627.

FOR OFFICE USE ONLY

ECN	Date Requested	Date Mailed

Provider Number	Effective Date
Provider Type	**Provider Specialty**

WISCONSIN MEDICAID
NURSING HOME PROVIDER APPLICATION

INSTRUCTIONS: Type or print clearly. Before completing this application, read Information and Instructions.

This application is for:

☐ Skilled Nursing Facility (SNF).
☐ Intermediate Care Facility (ICF).
☐ Change of Ownership, effective __ __/__ __ /__ __ __ __.

SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS

Special Instructions
Name — Provider Applicant — Enter only one name. All applicants (e.g., individuals, groups, agencies, companies) must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

Name — Group or Contact Person — Individual applicants employed by a group or agency should indicate their employer on this line. Applicants who are not employed by a group or agency may use this line as an additional name line or attention line to ensure proper mail delivery.

Address — Physical Work — Indicate address where services are primarily provided. This is the address used for mailing Medicaid information. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

Date of Birth — Individual / Social Security Number — Required for individual applicants only. Enter date as MM/DD/YYYY.

Name — Medicaid Contact Person and Telephone Number — List the name and telephone number of a person within your organization who can be contacted about Medicaid questions.

Medicare Part A Number and Medicare Part B Number — Required for Medicare-certified providers. Please use Medicare numbers appropriate for the same type of services as this application.

Name — Provider Applicant (Last or Agency Name, First Name, Middle Initial)			
Name — Group or Contact Person			
Address — Physical Work			
City	State	Zip Code	County
Date of Birth — Individual	SSN		
Name — Medicaid Contact Person	Telephone Number		

Current and/or Previous State Medicaid Provider Number

☐ Wisconsin ☐ Other

Medicare Part A Number	Effective Date
Medicare Part B Number	Effective Date

SECTION II — ADDITIONAL INFORMATION

Special Instructions

- **All applicants must complete question 1.**
- **Applicants who will bill for laboratory tests** must answer **question 2.** Attach a copy of their current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **All applicants certified to prescribe drugs** must answer **question 3.**

1. Individual or Agency License, Certification, or Regulation Number(s)

2. CLIA Number

3. Drug Enforcement Administration (DEA) Number

SECTION III — PROVIDER PAYEE NAME AND PAYEE ADDRESS

Special Instructions

Name — Payee — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

TIN — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

TIN Effective Date — This is the date the TIN became effective for the provider.

Name — Group or Contact Person (Optional) — Enter an additional name (e.g., business, group, agency) that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

Address — Payee — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

Name — Payee

TIN	TIN Effective Date	☐ EIN or ☐ SSN

Name — Group or Contact Person

Address — Payee

City	State	Zip Code

SECTION IV — TERMINATION / CONVICTION / SANCTION INFORMATION

During the preceding five years, has the applicant, any employee of the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, please explain:

SECTION V — TYPE OF BUSINESS

Fill in where applicable.

A. Governmental — Nonfederal:
- ☐ State.
- ☐ County.
- ☐ City.
- ☐ City-County.
- ☐ Other.

B. Nongovernmental — Nonprofit:
- ☐ Nonprofit association — Church
  1. Name _____
  2. Address _____
- ☐ Nonprofit Association — Other:
  1. Name _____
  2. Address _____

C. For Profit:
- ☐ Individual.

  Name _____

  Address _____
- ☐ Partnership.

  Names _____ Percent Ownership _____

  _____

  _____
- ☐ Corporation.

  Names _____ Percent Ownership _____

D. Federal government:
- ☐ Veterans hospital.
- ☐ Other (specify) _____.

Definitions for Sections VI and VII

Controlling interest — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

SECTION VI — CONTROLLING INTEREST ON OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, providers of any type of therapy.

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section VII.

Name

Medical Provider Number(s)	SSN / EIN

Address

City	State	Zip Code	County

Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

SECTION VII — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☐ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

Name — Individual or Entity

Address

City	State	Zip Code	County

Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership

TIN Number	Provider Number, if applicable

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

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State of Wisconsin

Department of Health and Family Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT
(Nursing Facility)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with (fill in name here)

_____,
(Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents.)

a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider is licensed under Chapter 50.03, Wisconsin Statutes, and ch. HFS 132 as a nursing facility and may provide and be reimbursed for the provision of nursing care under Wisconsin's Medicaid Program.

2. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended. If the Provider employs ten or more employees and receives $10,000 or more annually in Medicaid reimbursement, the Provider further agrees to comply with the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery.

3. That the Department shall reimburse the Provider for services and items properly provided under the program in accordance with a prospective reimbursement established annually pursuant to and in accordance with s. 49.45(6m) of the Wis. Stats.

4. The Provider agrees to furnish the Department with records necessary to fully disclose the extent of the services provided to individuals and information requested regarding any payments claimed for providing these services.

5. Unless earlier terminated as provided in paragraph 6 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

6. This agreement may be terminated as follows:

   (a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

   (b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

   (c) By the Department for failure of the Provider to timely correct the deficiencies identified in the facility's plan of correction, filed with and approved by the Department's Division of Health.

   (d) By the Department, at the direction of the federal Health Care Financing Administration (HCFA), or by the federal HCFA, acting under the authority of the Social Security Act upon a determination that the Provider no longer meets the requirements for participation in the Medicare program.

ALL PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER.

Name of Provider (Typed or Printed)

Physical Street Address

City State Zip

TITLE:

BY:
Signature of Provider

DATE:

(For Department Use Only)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH
AND FAMILY SERVICES

BY:

DATE:

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

PRINT CLEARLY, THIS IS YOUR MAILING LABEL. For recertification (renewals) ONLY.
Fill in the address below **IF** the processed Provider Agreement should be sent to a different address than the physical street address above.

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
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DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT
(Nursing Facility)

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ALL PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER.

Name of Provider (Typed or Printed)

Physical Street Address

City State Zip

TITLE:

BY:
Signature of Provider

DATE:

(For Department Use Only)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH
AND FAMILY SERVICES

BY:

DATE:

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

PRINT CLEARLY, THIS IS YOUR MAILING LABEL. For recertification (renewals) ONLY.
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WISCONSIN MEDICAID
ELECTRONIC BILLING GENERAL INFORMATION

Wisconsin Medicaid has several electronic billing options available for trading partners to submit electronic claims. HIPAA compliant Software is available at no cost for submitting claims to Wisconsin Medicaid except for retail pharmacy services. For further information, or to order free software refer to: http://www.dhfs.state.wi.us/medicaid9/pes/pes.htm or contact the Provider Services at 1-800-947-9627 or the EDI Department at 608-221-9036.

ELECTRONIC METHODS FOR SUBMITTING MEDICAID CLAIMS

- Provider Electronic Solutions (PES) – Wisconsin Medicaid HIPAA Compliant Free Software
    - 837 Institutional
    - 837 Professional
    - 837 Dental
    - 997 Functional Acknowledgement
    - 835 Health Care Payment Advice

- Cartridge - Providers with the capability to create their claim information on 3480, 3490 or 3490E cartridge can submit those tapes to Wisconsin Medicaid in the HIPAA compliant formats.

- RAS/Internet – Allows providers to send their data files to Wisconsin Medicaid using a direct RAS connection or Web Browser.

- Third Party Biller – Providers have the option of purchasing a billing system or contracting with a Third Party Biller, to submit their claims.